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ACUTE DIVERTICULITIS OF THE CECUM.

REPORT OF SIX CASES

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A CUTE DIVERTICULITIS of the cecum is another rare pathological condition which the surgeon occasionally encounters in that most fascinating right lower quadrant. It is important to realize that such a condition does exist, as many of us who have encountered it for the first time have submitted our patient to a needless and dangerous operation.

On gross appearance the lesion simulates a malignancy associated with some secondary inflammatory process. Closer analysis, however, readily demonstrates the fallacy of this assumption.

In order to bring out this point more clearly, let me review first my own experience with this condition, then the experience which we have had at the Rhode Island Hospital, and last, let us survey the facts as presented in our surgical literature.

Case #1-Dr. A. V. M.

Mr. C. G., age 30, presented himself at my office on January 2nd, 1942 with localized right lower quadrant pain of 24 hours duration. There was no associated nausea or vomiting. Examination revealed marked spasm and tenderness in this area. Rectal examination was negative and no abdominal mass could be made out. Temperature 99.2, Pulse 88, W. B. C. 14,300, with 92% polys. Patient was immediately hospitalized with a preoperative diagnosis of acute appendicitis. Operation was performed shortly after admission.

A McBurney incision was made. The peritoneum was opened and no free fluid was found. The appendix appeared normal. Exploration revealed a tumor of the cecum which showed evidence of definite acute inflammation about it. The mass was hard and about the size of a fifty cent piece. It was located on the medial and posterior walls of the large bowel distal to the ileocecal valve.

The McBurney incision was closed and a right rectus muscle-splitting incision was made. A lateral anastomosis of the terminal ileum to the transverse colon was performed.

During the operation, diverticulitis was considered, but no one in the room had ever heard of its occurrence in the cecum, therefore we reasoned that this case represented an early malignancy, and concluded that this patient had been fortunate in having some inflammatory reaction about the carcinoma.

A resection of the right colon was deemed inadvisable, as there was too much acute reaction about the lesion. Three weeks after the ileotransverse colostomy, a right colectomy was carried out. The patient made an uneventful recovery and was discharged within two weeks.

At the second operation we marveled at the decrease in the size of the tumor and attributed it to the disappearance of the inflammatory reaction resulting from the previous short circuiting operation. We were chagrined, when on opening the specimen, no tumor could be demonstrated. Only a small diverticulum was found. Part of the pathological report follows:

In the ascending colon, 3 cm. above the ileo-cecal valve, there is a small diverticulum-like structure. It measures 8 mm. in depth, and approximately 1 mm. in diameter. Within the pericolic fat there are identified several soft, pink notes which measure up to 1 cm. in diameter. They have a pink, bulging, cut surface. There is no gross evidence of tumor.

Microscopical Diagnosis—Diverticulitis of the ascending colon.

Case #2—Dr. A. V. M.

On January 15th, 1946, Mrs. M. C., age 52, was admitted to the Rhode Island Hospital with a provisional diagnosis of acute appendicitis, made by the family physician. The history was of generalized abdominal pain of twelve hours duration, continued on next page

X-ray showing diverticulum of cecum.



PLATE 1

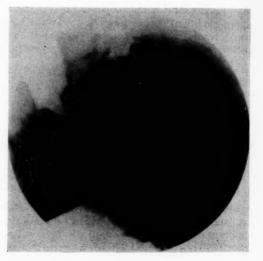


PLATE 2

which localized in the right lower quadrant. No nausea or vomiting. On physical examination, there was marked right lower quadrant spasm and tenderness as well as rebound tenderness. There was a questionable mass palpable. Temperature 98, Pulse 76, W.B.C. 8,900. My feeling was that this patient had an acute appendicitis in spite of the normal T.P.R. and W.B.C. Operation seemed indicated and it was carried out.

McBurney incision. Peritoneum opened. A small amount of fluid was found, and culture taken. Cecum was bound down. The posterior wall was hard and showed definite signs of inflammation. There was considerable edema of the posterolateral wall, as well as edema of the fatty tissue in this neighborhood. The appendix, except for chronic inflammatory reaction, showed no evidence of recent inflammation. The terminal ileum was normal.

Because of the fact that there was so much acute inflammation about the cecum, and because of the possibility of a solitary diverticulitis, it was decided not to do anything about this lesion until further study could be carried out.

In this case I was confronted by the same gross pathological condition that was present in the first case. The condition was recognized and the cecum was not molested. Some may justifiably criticize the appendectomy. If the situation were to present itself again, appendectomy would not be carried out.

Postoperative treatment consisted of sulphasuxidine and a low residue diet.

A barium enema was ordered while the patient was still in the hospital. The following is the report, as well as a photograph of the X-ray.

January 22nd, 1946—Barium enema disclosed a marked irritability of the cecum, and it was impossible at two separate examinations to fill and outline the cecum for a sufficient length of time to demonstrate any definite organic defects or abnormalities in this area. The head of the cecum appeared deformed and slightly narrowed, and there was a small saccular projection which appeared to arise from the lateral surface opposite the ileo-cecal valve and may represent a solitary diverticulum. The remainder of the colon was of normal calibre and outline throughout, and disclosed no abnormalities. Some of the ileum was well filled and appeared normal.

Impression—A definite diagnosis is not warranted, but the findings suggest an inflammatory process or lesion involving the head of the cecum. Request repeat examination before six weeks.

A second barium enema was taken on March 20th, 1946, approximately three months after the acute episode, and a diagnosis made of a diverticulum of the posterior aspect of the ceco-colinic segment. A photograph of this finding follows.

Note that the X-ray shows the presence of a second small diverticulum on the lateral border of the cecum. The finding of more than one diverticulum in the cecum is not unusual. However, only one of the diverticuli present becomes inflamed. In this case it was the large one on the medial aspect.

Also note that the diverticulum, which is so obvious in this picture could not be demonstrated in the X-ray which was taken one week after the acute onset of the disease.



PLATE 3

Case #3-Dr. E. M. P.

Mr. P. E., age 54, admitted June 22nd, 1946. Fifteen hours before admission noted onset of sharp right lower quadrant pain. Pain was localized, but kept patient awake for more than five hours. Pain disappeared, but then recurred and patient felt feverish. No mention of nausea or vomiting. L.M.D. found temperature to be 100.2, P. 80, W.B.C. 13,500. On admission, several hours later, temperature was 100.6, W.B.C. 12,450.

Physical examination by interne and visiting surgeon showed slight tenderness to deep palpation.

Questionable rebound tenderness.

Preoperative diagnosis—Mild acute appendicitis. Operative note: McBurney incision. The cecum was high. The appendix was located and found to have a very edematous mesentery. The mesentery of the terminal ileum was also edematous. Although appendectomy was performed it was evident that the appendix was not pathologic and with some traction the cecum was brought down. Examination showed a large mass involving the cecum at, and above the region of the ileocecal valve. The terminal ileum was involved in the mass, and at first it was thought that there might be an intussusception. The incision was enlarged. The mass was distinctly inflammatory in character. There was marked edema in the retroperitoneal region and in the mesentery of the ascending colon.

A right colectomy with an ileotransverse colostomy was performed.

Pathological report—"The outer surface of the large bowel is covered with fat, and just distal to the ileocecal valve there is an area of redness and induration, 4×4 cm. On the mucous surface, a cavity is noted just distal to the ileocecal valve, which is $1.5 \times 3.2 \times 1$ cm. The transverse folds leading to the opening into this cavity are red and edematous."

Microscopic section shows massive infiltration with polys, fibrin, erthrocytes and edema.

Diagnosis—Acute diverticulitis of the cecum.

Postoperative course was complicated by a partial atelectasis of the left lung. The patient was discharged on the 22nd post operative day.

Case #4—Dr. D. V. T.

Miss T. B., age 26, admitted October 9th, 1947. Abdominal pain, three days duration, mostly in the epigastrium, but vague and poorly localized. No nausea or vomiting. Twelve hours before admission, pain localized to the right lower quadrant and became severe.

Physical examination—Tender right lower quadrant, and slight spasm. No rebound tenderness. Hyperactive peristalsis. Small, hard, round, tender mass in the right lower quadrant. T. 101, P. 120,

R. 22, W.B.C. 18,500, 67% polys.

Operative note—Right rectus incision. No free fluid in peritoneal cavity. A large mass was found at the cecum involving the base of the appendix and numerous glands were seen extending to the root of the mesentery. They were not hard, and not like carcinoma, but shiny and soft, and looked like tuberculous glands. The lesion was about the size of a hen's egg. There was a question as to whether or not this was a diverticulitis with infection, or tuberculosis, or even carcinoma.

A right colectomy with ileo transverse colostomy

was performed.

Postoperative course was relatively smooth and the patient was discharged on the 9th postoperative day

Pathological report—Gross—In the cecum, just lateral to the ileocecal valve is a 1.0 cm. orifice into a diverticulum which is 1.7 cm. long. The wall of the diverticulum is 4 mm. thick and is pinkish gray and firm on section. A fecalith, measuring 1.8 cm. in greatest diameter is in the diverticulum.

Microscopic sections showed suppurative diverticulitis of the cecum.

Case #5—Dr. D. V. T.

Mr. J. A., age 30, admitted August 11, 1946. Vagus pain three weeks previously, which returned two days previous to admission and localized in R.L.Q. No vomiting.

Physical examination—Spasm and tenderness in

R.L.Q. Rebound tenderness present. Rectal showed tenderness on right, but no mass was palpable, either rectally or abdominally. T. 100, P. 104, R. 24, W.B.C. 12,400. Diagnosis—Acute appendicitis.

Operation—McBurney incision. No free fluid found on opening abdomen. Appendix was found moderately injected, but did not appear to be the cause of his symptoms. Appendix was removed. Exploration with the hand revealed a mass just below the hepatic flexure of the colon. Incision was enlarged and inspection revealed an old abscess involving the colon at the point of its mesentery, and marked edema of the surrounding fat. It was deemed not wise to explore this at this time. Wound was closed without drainage.

Postoperative course was essentially uneventful. The temperature remained elevated for about five days, but showed a gradual decline.

Barium enema, six weeks later, showed multiple diverticulosis involving the entire colon from cecum to rectum.

This case is included as it shows acute inflammation in a diverticulum of the ascending colon in a patient with diverticulosis. Even those cases reported having a solitary diverticulum, often will show evidence of more than one diverticulum. This is well demonstrated in my second case, by the x-rays which were taken three months after the acute process had subsided.

Case #6-Dr. E. S. C.

Mr. H. K., Age 32, admitted February 9, 1947. Abdominal pain, 30 hours duration. Onset at the umbilicus, then shifting to the R.L.Q. No nausea, vomiting or diarrhea. Slept well the night before admission, but on day of admission was unable to stand erect and had to walk slightly bent over.

Physical examination:—Moderate, but definite tenderness in the appendiceal region. Increased muscle resistance, R.L.Q. extending into flank. Temperature 100, Pulse 112, W.B.C. 17,520. Preoperative diagnosis—acute appendicitis.

Operation—Abdomen opened through a transverse incision. The appendix was normal. An indurated mass could be felt over the anterior surface of the upper cecal region. The cecum was delivered, and found to have a gangrenous diverticulum, which was freed from the adherent indurated fatty tissue. This mass came off the cecal wall, just about at the site of entrance of the terminal ileum. The mass was excised and the opening closed. A #20 catheter was sutured into the terminal ileum by the Witzel method. Routine appendectomy was performed. Specimen examined by the pathologist as soon as it was removed. No malignancy found.

Pathological Diagnosis — Acute diverticulitis (with perforation in subperitoneal fat."

Postoperatively, this patient developed an acute cholecystitis, which had to be treated surgically.

The six cases reported represent all of the known cases of this nature which were diagnosed and treated at the Rhode Island Hospital. It is curious that all of these have been seen within a six year period, from 1942 to 1947. It is interesting that nausea and vomiting were not present, and that the preoperative diagnosis in each one was acute appendicitis. In only two of the cases a questionable mass was palpated. One of the diverticuli contained a fecalith. Two of the cases showed more than one diverticulum when x-rays were taken postoperatively.

The treatment consisted of a primary right colectomy in two cases, an ileotransverse colostomy, followed by a right colectomy in one case, an appendectomy in two cases, and a diverticulectomy in one case.

The only postoperative complications were an atelectasis in one case, and an acute cholecystitis in another case.

There were no deaths.

The following factors in this differential diagnosis are summarized for the most part from J. W. Baker's article.

- 1. Carcinoma of the cecum is of three types.
 - a. Cauliflower like projections into the lumen of the bowel. Metastasizes slowly.
 - Growth is by direct extension through or along the various coats of the bowel, and is a little more apt to show glandular metastasis.
 - Ulcerates rapidly through the bowel wall and at operation shows glandular metastasis.

2. Tuberculosis

- a. Small tubercles usually are seen on the serosa.
- b. Ileum usually involved.
- c. Lymph glands are large and caseous.
- d. Adhesions usually present.
- e. Hyperplastic and ulcerative forms exist.

3. Actinomycosis

- a. Starts in cecum or appendix.
- b. Wall thickened.
- c. In later stages abscesses form which may open though sinuses in abdominal wall discharging characteristic sulphur granules.
- 4. Non specific granulomatous lesions.
 - a. Usually involve ileum.
 - b. Thickened bowel wall.
 - c. Granular appearance of serosa.
 - d. Edematous mesentery.
 - e. Glands usually present and inflammatory in nature.

- 5. Non specific ulcer.
 - a. As rare as solitary diverticula.
 - b. Have same complications as peptic ulcer.
 - (1) Perforation—acute or subacute
 - (2) Hemorrhage
 - (3) Obstruction.

6. Simple inflammatory tumors of cecum.

In acute solitary diverticulitis of cecum, we have a rather short history of an acute abdominal condition in an individual who is usually under 45. The physical findings, and/or the laboratory results, substantiate the impression that acute appendicitis is the most likely diagnosis. At operation, the appendix shows little or no pathology, while a localized area in the cecum presents all the signs that one would expect to find in an acute inflammatory process.

The literature on this subject, while limited to the review of the known 100 cases, repeatedly emphasizes that conservative surgery is indicated,

- 1. Do nothing, unless a complication is present.
- If carcinoma cannot be ruled out, it is safer to do an ileotransverse colostomy, and wait until the acute inflammation has subsided before doing any definitive surgery.
- When present, attempt to dislodge the fecalith and invert the diverticulum.
- 4. Do a diverticulectomy if perforation seems impending, or has already taken place.

d

The medical treatment of acute uncomplicated diverticulitis of the cecum should consist of sulphasuxidine in preference to sulphathilidine, as the former has a tendency to keep the stool soft. In addition, a low residue diet, plus rest in bed are necessary until all the local signs have subsided. Penicillin and streptomycin can be held in reserve, and used whenever necessary.

It is quite possible that the occasional post-appendectomy patient who presents himself later in life with all the signs and symptoms of an acute appendicitis, may in reality be the victim of an acute cecal diverticulitis. Most of the patients will do well if left alone.

The further care of an uncomplicated case of acute diverticulitis, after it has subsided, will vary. X-ray studies are essential. If the diverticulum is large or is troublesome, diverticulectomy can be carried out easily after proper preparation of the colon.

Summary

Six additional cases are reported.

Acute diverticulitis of the eecum is a definite disease entity which must be considered whenever an inflammatory mass is found in the eecum, especially if the preoperative diagnosis is acute appendicitis.

Suspect the lesion and you will avoid pitfalls in the treatment of this disorder. Conservatism is indicated unless complications are present.

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AMA MEETING

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SOME ASPECTS OF AVIATION MEDICINE*

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Man is said to be a most adaptable animal. He readily accommodates himself to either the frigid polar regions or the torrid tropics. He can adjust himself to a wide range of temperature, humidity and living conditions. This he is able to do because he has had millions of evolutionary years in which to become physiologically and psychologically adapted to these climatic and environmental extremes.

But, within a short 46 years; within the life time of many of us here, he has projected himself into a new environment. An environment for which he has had little or no evolutionary preparation—altitudes far above the highest mountain and speeds far exceeding the wildest dream of only a generation ago.

Since man is not physiologically adapted to the decreased atmospheric pressure, and to the acceleration incident to operations in his new environment, it has been the job of the Flight Surgeon and the physiologist to compensate for his deficiencies by artificial means.

In 1875, TISSANDIER, a French Meteorologist, and two companions ascended to 28,820 feet in a balloon. This was the first recorded instance in which supplementary oxygen was carried in flight. Since only a limited quantity of oxygen could be carried in the small balloonette containers, it was agreed that it would be used only if the aeronauts *felt the need of it*. Tissandier's two companions died of anoxia. He himself landed with the still unused oxygen supply.

Tissandier was one of the subjects used by the great French physiologist, Paul Bert, in his exhaustive investigations of the phenomena of decreased barometric pressure. Three years after this fateful flight BERT published his now famous, "La Pression Barometrique", the first authoritative treatise on the physiology and physics

* Presented at a Joint Meeting of the Rhode Island Medical Society and the Providence Medical Association, at the U. S. Naval Air Station, Quonset Point, R. I., February 2, 1949 of high altitudes. It is of interest to note that in this first oxygen flight Tissandier and his two companions exhibited the classic symptoms of anoxia; mental confusion, loss of judgment, and unconciousness. Though the life saving oxygen was readily available they were incapable of using it. Many have died since then; victims of this syndrome.

The composition of the atmosphere is; oxygen, 20.93%; Nitrogen, 79.04%; Carbon Dioxide. 0.03%. Included in the nitrogen percentage are the traces of rare gases such as Krypton, Argon, etc. This percentile relationship of atmospheric components remains essentially unchanged at all altitudes. The atmospheric pressure does change, however, and; in obedience to the basic physical laws governing gases, as the total atmospheric pressure decreases, so does the partial pressure of oxygen. The gaseous exchange taking place in the alveoli is also governed by the fundamental physical law of gases; gases diffusing from areas of higher partial pressures to those of lower partial pressures. As the partial pressure of oxygen decreases with altitude there is decreased diffusion, resulting in lowered oxygen concentrations in the blood.

At sea level, with an atmospheric pressure of 760 mm. Hg. the partial pressure of oxygen is approximately 159 mm. Hg. At 18,000 feet, where the total atmospheric pressure is only one half of that, the partial pressure of oxygen is decreased to approximately 79 mm. Hg. This pressure is halved again at approximately 35,000 feet. These figures represent the partial pressure of ATMOS-PHERIC oxygen. But, the concentration of oxygen in the blood is dependent upon the partial pressure of ALVEOLAR oxygen, and the composition of Alveolar air is considerably different from that of the atmosphere. The oxygen has become diluted with Carbon Dioxide, and most important, it has become saturated with water vapor. The partial pressure of water vapor in saturated air is 47 mm. Hg., and this figure remains constant in the Alveolar air at all altitudes. Thus, at sea level, the effective pressure of Alveolar air is 760 mm. Hg., minus 47 mm. Hg. partial pressure of water vapor. The oxygen content has been diluted to approximately 15.5% and the Carbon Dioxide has increased to about 4.5%. The resulting partial pressure of

Alveolar oxygen is approximately 110 mm. Hg. At 18,000 feet the Alveolar Oxygen tension is only about 52 mm. Hg. and is further reduced at greater altitudes.

At sea level, with an Alveolar Oxygen tension of 110 mm. Hg., the arterial blood is about 96% oxygen saturated. At 10,000 feet the percentage has dropped to about 90% saturation, and there are no detectable symptoms of anoxia. At 15,000 feet the oxygen saturation averages about 83%, and the effectiveness of a pilot is definitely impaired At 18,000 feet he is seriously handicapped and may lose consciousness after 15 to 30 minutes at this altitude. At 30,000 feet, coma, collapse and death ensue in a very short time.

Use of Supplementary Oxygen

It is not enough that a pilot just remain reasonably conscious, however. He must be in full command of all his faculties to be able to fly formation, engage in aerial combat, navigate, etc. In order to maintain this high degree of pilot efficiency, the services require the use of supplementary oxygen at altitudes above 10,000 feet for daylight flights and above 5,000 feet for night flights.

The difference in night and day oxygen requirement is based on the relatively greater sensitivity of the retinal rods, the principle organs of night

vision, to even minor degrees of anoxia. Currently used oxygen equipment, the "diluter demand", type is designed to provide the increasing percentage of oxygen in the inspired air required to maintain satisfactory blood oxygen saturation at high altitudes. The percentage of supplementary oxygen supplied by this equipment ranges from zero at sea level to 100% at approximately 32,000 feet.

As can be seen from the following equation: partial pressure of a gas in a mixture equals the percentage of the gas divided by 100, and multiplied by the ambient atmospheric pressure, a pilot breathing 100% oxygen at 32,000 feet is at the

physiological equivalent of sea level.

As the pilot climbs to higher altitudes, and the total atmospheric pressure further decreases he soon finds that even 100% oxygen is not sufficient. This occurs at about 40,000 feet, where the physiological equivalent altitude is about 11,000 feet. Beyond this altitude the pilot must have more help. "Pressure breathing" oxygen equipment is designed to furnish this added assistance by forcing the pilot to breath against increased expiratory resistance, thus increasing intrapulmonary pressure by a small amount. The increased Alveolar oxygen tension thus produced enables the pilot to ascend to approximately 43,000 feet. Beyond this he again needs help.

Since the basic factor in the problem of maintaining adequate blood oxygen saturation at alti-

tudes is ambient atmospheric pressure, the solution is simply to increase this pressure artificiallypressurize the pilot's cockpit.

Problems of Pressurization

This is not as simple as it sounds. It introduces numerous problems of ventilation, increased weight and complexity, adequate safety features, etc. It also introduces a new and potentially dangerous hazard-explosive decompression. That is, the rapid decompression which results when the cabin pressure is suddenly lost, as when a cockpit canopy is carried away, or in case of failure of the pressurizing equipment.

It has been determined experimentally that the gases contained in the lungs, stomach and intestines can be suddenly expanded to 2.3 times the original volume without serious tissue damage. Cockpits must be designed, and differential pressures controlled so as not to exceed this figure.

The ideal pressurization would maintain a cockpit at an equivalent altitude of about 5,000 feet at all altitudes. This would eliminate the requirement for oxygen altogether. However, the weight and complexity of such a system would be prohibitive. And, since oxygen must be carried for emergency use in cases where the cockpit loses its prescontinued on next page



Captain Julius C. Early, MC, USN, of Washington, addressing the mid-winter meeting of the Rhode Island Medical Society at the Quonset Naval Air Station.

(Official U. S. Navy Photograph)

sure from any cause and for use in high altitude bailouts, such an ideal system is not considered practicable. In addition, since the difference between the cockpit pressure and ambient pressure is an important factor in determining the rapidity of decompression, along with cockpit volume, and the size of the opening through which the cockpit is decompressed, the differential pressure should be kept at the lowest value consistent with physiological requirements. From the consideration of oxygen requirements, 30,000 to 40,000 feet equivalent cockpit altitude is satisfactory provided 100% oxygen is used. However, at 20,000 to 25,000 feet the occurence of aero-embolism, or "Bends", become a problem. Recent studies indicate that the incidence of this disabling phenomenon varies between 10% and 40% at 30,000 feet, depending upon the degree of muscular exercise and the length of exposure. Since only light muscular effort is required of a fighter pilot in flying his plane, the lower figure is probably the realistic one from a military point of view. Therefore, this is the maximum equivalent cockpit altitude allowable, except for short periods of time when a cockpit equivalent altitude of 40,000 feet is permissible.

The pressurized cockpit satisfies our requirements at current operating altitudes-so long as the pilot remains in the pressurized cockpit. Unfortunately, however, there exists the possibility that the pilot might have to leave his plane at extreme altitudes. Since the time of useful consciousness without supplementary oxygen is on the order of 15 to 20 seconds above 40,000 feet, it becomes necessary to provide a separate emergency bailout oxygen supply. Further, above about 50,000 feet there is the probability of dangerous and even fatal anoxia even when breathing 100% oxygen—not to mention the disadvantages of a temperature of -65° F. At 63,000 feet and above the blood plasma actually boils. It is obvious that a safe bailout from above 50,000 feet can be made only if the pilot himself is pressurized. Work is progressing on this prob-

The foregoing is only a partial enumeration of the physiological problems arising from man's invasion of altitudes to which he must be artificially adapted. It is obvious that there are many other factors influencing respiratory and blood and tissue concentration of oxygen and carbon dioxide. Smoking, which produces a carbon monoxide concentration of the blood; anemias, which reduce the oxygen carrying power of the blood; drugs such as alcohol, which decreases the tissue utilization of oxygen; and general physical condition of the pilot, are only a few.

New Problems for Pilot Safety

So much for the physical and physiological aspects of altitude.

With the advent of the high speed jet aircraft of the past few years and the prospect of attaining even greater speeds in the near future, aviation medicine was faced with an imposing array of new problems of pilot comfort and pilot safety. It would be futile to build high performance aircraft if they were to be flown in combat by low performance pilots. Pilots had to be artificially conditioned to withstand the 7 to 8 "g" pullouts from a divebombing attack, and the sustained high "g" turns and manuevers of aerial combat, if the full capabilities of his plane were to be realized.

The average pilot will "blackout", and may lose consciousness, when subjected to a force of 4.5 to 5.5 "g", for 3 to 5 seconds.

In order to prevent the cerebral anoxia resulting from the pooling of the blood in the lower extremities and abdominal viscera under such a force, the now commonly used "anti-blackout" suit was developed.

This device is basically simply a number of bladders, properly placed about the lower legs, thighs, and lower abdomen. Under "g" loads these bladders are automatically inflated so as to compress the lower parts of the body, reducing the volume of blood pooled in these areas, thus delaying the onset of "blackout" and unconsciousness. By this means the pilot's tolerance to acceleration is increased from 1.5 to 2 "g". This gives him a considerable advantage over an enemy pilot who is not so protected; enables a divebomber to make faster pullouts and escape from anti-aircraft fire; and decreases to a considerable extent the marked fatigue usually resulting from the strain of such maneuvers.

The increased speeds of modern jet and conventional aircraft increases the hazard and difficulty in escape from such planes in emergencies. At speeds above 300 m.p.h., bailout becomes dangerous, and under some conditions, impossible. It was necessary that the pilot be forcibly ejected from the aircraft by some mechanical means.

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During the last war the Germans developed such an ejectable seat. Allied pilots were startled to see their opponent suddenly pop out of their fast planes like a jack-in-the-box, when their plane was damaged in combat. This German development was somewhat dangerous and unreliable. Since then, however, the British, the U. S. Navy and the U. S. Air Force have developed a satisfactory ejectable seat; though each employing somewhat different design. The British have made a successful live ejection from a Meteor airplane at 505 m.p.h. The U. S. Navy and Air Force have made numerous successful dummy and live ejections at lower speeds.

The problems associated with the development of such a seat were numerous, and, since heretofore it had not been necessary to make a pilot into a human projectile, many of them were entirely new. How much impact force would be necessary to project a pilot at sufficient speed and to sufficient heighth to clear the airplane at such high speeds, and could the pilot safely withstand such a force? What would be the effect of suddenly thrushing a pilot into an air blast of 500 m.p.h.? What would be the aerodynamic effect on such an un-streamlined mass at high speeds? What is the upper speed limit beyond which this means of escape cannot be safely employed? Would the pilot accept this unusual means of escape in an emergency? Satisfactory answers to most of these questions have been found, and this device is now part of the equipment of most high speed aircraft.

The problems of pilot escape from aircraft capable of supersonic speeds has not been satisfactorily solved as yet. It appears that the problems of jettisoning a capsule containing the pilot, or a whole cockpit, are more the problems of the engineer and the aerodynamicist than those of the flight surgeon and physiologist, though there are physiological considerations involved. These are concerned with pilot comfort at supersonic speeds as well as acceleration forces of a jettisoned capsule or cockpit.

The familiar phenomenon of a meteorite being consummed by the intense heat generated by friction as it enters the earth's atmosphere brings us to the problem of protecting the pilot against the extreme friction or ram effect temperatures of transonic and supersonic speeds.

A few figures will indicate the magnitude of the cockpit cooling required. At 700 m.p.h., and at sea level, the temperature rise, due to friction and ram effect alone, is 75° F. At 1,000 m.p.h., it is 150° F. At 1,500 m.p.h., it is 340° F.—about the temperature used in cooking a beef roast. The cockpit temperature of the Navy's "Skystreak", flown at 656 m.p.h., by Marine Major Marion Carl, would have totaled 178° F. without refrigeration. This includes ambient temperature, solar radiation, heat from the power plant, and friction heat.

The capacity and complexity of a refrigeration unit capable of maintaining a comfortable cockpit temperature under these conditions, and still light and compact enough to be installed in a fighter aircraft, is a real design problem.

Many Sunday supplements have been written concerning the physiological hazards of sound and vibrations in the operation of jet engines and jet aircraft. Some impressive effects of sub and supersonic noise on laboratory animals have been reported. In regards to the effect of such noises and vibrations on man, much is yet to be learned. Spectral analysis of the sound fields about a jet engine running at full power reveals a wide range of frequencies and amplitudes. However, so far studies have revealed no startling effects on personnel ex-

posed to such noise. The one constant finding is a reversible hearing loss, particularly for the higher frequencies. Some subjects complained of headaches, fatigue, dizziness, anorexia, and loss of weight. One seventeen year old subject stated that he had noted that he had to shave more frequently than before the beginning of the study.

This is about as far as I shall go at this time in enumerating the trials and tribulations with which flight surgeons and physiologists are beset. I have not touched on psychological problems, such as Selection, Morale, etc., or those of the strictly medical nature involved in care of the pilot and his treatment during illness. But, I think I have said enough to indicate what a race it is between the engineer and the aerodynamicist on the one hand, and the flight surgeon on the other.

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CUTANEOUS MANIFESTATION OF A TRAVELING NEEDLE

F. RONCHESE, M.D. Providence, R. I.

The Author: Francesco Ronchese, M.D. Dermatologist in Chief, Rhode Island Hospital, Assistant Professor of Dermatology, Boston University.

A CLEAR EXAMPLE of a dermadrome* is the foreign-body dermatitis due to a traveling needle pushed by the mysterious forces of nature out the body as an undesirable guest.

Some years ago an elderly woman, while under my care for a common eczematoid dermatosis of the hands, developed something in appearance like a furuncle on one thigh. The discomfort usually accompanying such a lesion was absent. Because of varicose veins she was taken to the Rhode Island Hospital for an infra-red photograph. Surprisingly enough, a roentgen plate, obtained for the sake of completeness, showed a sewing needle on the last stage of its way through the woman's body, trying to force its way out through the skin of the thigh.

How the needle got into the woman's body remains a mystery. Probably she sat in a comfortably

upholstered chair which was harboring the needle in the right position for a stab which produced so little discomfort as to be overlooked.

Comment

This case report, comparatively minor in importance, shows how wide the field of dermatology is and how multiform the diagnostic possibilities are, even in the most apparently trivial skin lesion.

Summary

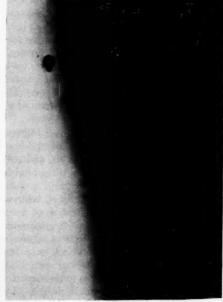
A case is described of a traveling needle producing a follicular-like foreign body reaction in the skin in attempting self expulsion.

References

Rogers, L., Migration of Foreign Bodies, Laucet, 2:535, 1942., Shapiro, S., Passage of Hollow Needle into Venous Blood Stream to Heart through Cardiac Wall and into Thorax, Heart J. 22:835, 1941.

*Dermadrome is the term used by Wiener in his book: Skin Manifestations of Internal Disorders, Mosby, 1947, to describe the traveling of a disease from the inside of the body to the cutaneous surface.





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Foreign body skin reaction of furuncular appearance on one thigh from a sewing needle entered, presumably, through the buttock and trying to escape through the thigh.

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GOVERNMENT MONOPOLIES

ONE of the most interesting observations to be made about the current controversy regarding national health insurance is that government monopoly, whether federal or state, is held by its proponents to be not only proper and American, but also the most beneficent way to administer a program for the public's good.

Here in Rhode Island this theory of monopoly has been strongly supported by those who advocate increasing controls by government over the private lives and affairs of our citizens. As physicians we probably have no right to lay claim to be economists of professorial rank. But we do recognize a false diagnosis, whether it is in medicine or in economics.

Consider what has happened to the employed workers of Rhode Island under the State's monopoly of the cash sickness compensation program as an outstanding example of the point we make here. Every worker, every citizen, is told that the Rhode Island cash sickness compensation plan is the best of its type, the ideal plan, and the one that has been copied by other states. And why is it so good? Because through the state monopoly the worker gets the most for his pay check deduction, and he should be happy that he doesn't have to pay his

hard earned money into the profit-making insurance industry. Preach that theory intensely and continuously and you begin to understand how peoples are lulled into a socialist state.

Let's see what is really happening beyond our monopolistic borders.

California adopted a disability compensation program two years ago which avoided all the faults of the Rhode Island plan, including the state monopoly of the fund. The insurance industry of America was permitted to participate, but with the condition that their provisions for the employed worker *exceed* those offered by the State, and at no higher premium. What happened? In spite of this penalty the insurance industry has already written 35% of the business in California, and has given the worker more benefits than the State agency awards him. Yet the insurance companies still have to run their organizations on a business basis and at a profit.

Last year New Jersey adopted a disability compensation program copied after the California plan, *not* the Rhode Island program. Representatives of organized labor from our State supported labor leaders in New Jersey in pressing for a state continued on next page monopolistic fund because it was supposedly so successful here. They did not prevail in their efforts, and the New Jersey act provided for insurance company competition against the State agency. What has been the result?

Within six weeks after the New Jersey law was in effect, fifty per cent of the disability compensation business had been written by private insurance, and the biggest problem of the companies was that of handling the tremendous volume of business. And who benefits in New Jersey as the result of the open competition? The worker does!

The following comparison is one example of what happens under the American competitive system

The New Jersey State cash sickness plan provides benefits of approximately sixty per cent of weekly earnings up to \$22.00 per week benefit, based on past wage history in the same manner as Unemployment Compensation benefits. A typical private insurance company will provide sixty-six and two thirds per cent of weekly earnings up to \$27 per week benefit—a higher percentage on higher amounts—and in addition, if the worker is hospital confined his benefits otherwise payable are increased fifty per cent.

Again, the State agency begins benefits with the 8th day of disability and pays benefits from 10 to 26 weeks during any 12 consecutive months. But the insurance company plan will pay up to 26 weeks for EACH period of disability, regardless of past wage history.

Under both programs, the State Fund with its limited benefits and the Insurance Company plan with its far more liberal benefits, the cost to the employee is the same—three-fours of one per cent of the first \$3,000 of annual earnings!

On last March 22 the State of Washington cash sickness bill was approved by the Governor. But Washington, too, did not think much of the Rhode Island cash sickness setup. An Assembly-appointed committee visited here three years ago for a first hand study, and its findings apparently convinced their legislators that the California and New Jersey proposals for competitive insurance are best for the employed worker.

On the last day of March this year the New York state legislature passed the Mailler-Condon cash sickness bill which departs from the pattern heretofore established in other states where the legislation has been an extension of the Unemployment Compensation. The New York bill is an amendment to the Workmen's compensation Law through the addition of a new article providing temporary disability benefits and places the program under the supervision of the chairman of the workmen's compensation board. Beginning July 1, 1950, employers of four or more are required to provide the benefits either through insurance with private insurance companies, through

insurance with the state compensation fund, or as a self-insurer.

Covered employers under the New York plan are authorized to withhold one-half of one per cent of the wages of their employees, but not more than \$.30 per week, to help defray the cost of these benefits. The balance must be paid by the employers.

Thus the pattern continues to be drawn on new and better lines on the basis of experience. That process is one of the reasons why the autonomy of our 48 states provides a great bulwark against the aspirations of federal control minded individuals who would deny to our states their rights of self-government. In every instance the monopolistic Rhode Island cash sicknes program has been repudiated, and yet after seven years of it here no effort has been made to eliminate the government monopoly in order to help the worker who is paying the entire cost of the compensation. Even organized labor has failed to act in behalf of its members.

Consider the present economic status of the Rhode Island cash sickness plan. The contributions in the first quarter of 1949 were \$1,140,574.11, while the total operating cost, including benefits paid out, amounted to \$1,059,712.60. On a pay-asyou-go basis, therefore, the fund has actually only \$80,861.51 surplus. But by reason of the employee donations to the unemployment compensation program prior to the adoption of the cash sickness act, a situation that existed in only four states, Rhode Island received a windfall of thirty-five million dollars which it can now use as a reserve fund for cash sickness. The first quarter interest this year on this fund amounted to almost \$246,000.

Where other states are able to operate cash sickness plans offering more to the worker at the same or less charge than the Rhode Island plan permits, we continue to hold allegiance to the fallacy that the state monopoly is superior.

What about compulsory taxation for a government monopoly to provide medical care? Is there any reason to believe that the pattern would be different? Would not all of us be faced with a situation comparable to our state cash sickness program, in which the beneficiary is forced to accept whatever arrangement the government agency dictates, with no alternative plan and with no competitive factor to provide higher benefits for minimum assessment on wages? We certainly would.

America was built on the theory that competition makes for a better product. The voluntary system is still superior to the government monopoly. But unless more of our people shake off the shackles of a paternalistic system that seeks by legal methods. by appeal to humanitarian motives, and by political manipulation, to discredit the voluntary system and thereby establish the government monopoly, we will most certainly achieve socialism by evolution as effectively as other nations have sought it through revolution.

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1949-50

TO THE OFFICERS AND FELLOWS OF THE RHODE ISLAND MEDICAL SOCIETY

THERE was a time when the life of our state medical society was a placid one. All the members wished to treat their patients well and the chief task of the society was to help them in their education that they might do this. Those days are gone. We can no longer concentrate on diagnosis and treatment.

The problems that have been keeping the officers and committees busy and vexed are social, political and economic. No one needs to be convinced that mankind has so far failed in solving any of these problems. There are some of us including the writer who feel that no large group has on the whole done better than American physicians.

But an earnest vociferous minority have certainly exaggerated our shortcomings and are demanding precipitous action. Nature works by evolution. Mankind is forever demanding revolution.

We are told that Aesculapius, God of Medicine, had two daughters. Hygiea though not a spectacular beauty is virtuous and a perfect helpmate. Medicine has taken her to its heart. The other daughter, Panacea, is a high bosomed hussy, the kind that leads men astray. Whether she comes bearing a cornucopeia of endocrine tablets or a sheaf of bureaucratic paper forms, beware of her advances.

The society has made itself a force in local matters and should continue to do so. Thus it has through its committee helped to reorganize Workmen's Compensation. This bids fair to be an improvement. The clearing up of water pollution has been spearheaded by us. This congested community is woefully lacking in healthy recreational facilities. Our formerly beautiful bay is our greatest potential asset. May we force more improvement in the future.

The virulent critics of our great national association have referred to the money being raised by assessing each member as a "slush fund". Tremendous adverse publicity has been used against us, much of it through federal offices supported by tax money. How are we going to wage on a large scale what we feel to be an honest defensive campaign unless we have the funds openly and frankly obtained from our members?

Our state medical Journal has criticized the officers and committees at 535 North Dearborn Street for we know well they are human and fallible. But never for a moment have we deluded ourselves by the airy phantom that we would get improvement if medicine were put under political control.

The A M A is a democratic institution. The House of Delegates have absolute power. Each member is appointed by his state society and each member of the state society has the right to talk and vote. I think our motives are high and that those physicians who choose to quarrel with them through the public press are not promoting them.

Close contact with and observation of my recent predecessors has shown me that the task of President is a big one. They have been conscientious, industrious, and intelligent. I trust I can show the same qualities.

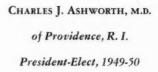
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WHAT INSURANCE COMPANIES ARE DOING AND CAN DO TO EXTEND MEDICAL CARE IN NEW ENGLAND*

HENRY D. LOCKE, PH.D.

The Author. Henry D. Locke, Ph.D., Research Director for the Liberty Mutual Insurance Company, Boston, Massachusetts.

WHAT I PROPOSE to do is, first, to present some facts with respect to the coverage presently available and how much coverage is in force in New England; making some comparisons between New England and the country as a whole. This background of data must be weighed against the goals established by the Federal Security Agency—and let me tell you now, that I think you will be impressed by what the voluntary agencies have already achieved.

Impressive as this comparison is, especially in light of the growth trends which are revealed, we are still a long way from our ultimate goals. There are, however, compelling reasons why these goals may come nearer to ultimate fulfillment by building on established patterns than by endorsing a uniform compulsory scheme that is irreconcilable with our basic American concepts of freedom and democracy.

If government permits competitive enterprise institutions to continue the growth and expansion in the volume of medical care coverage furnished, the wide number and variety of agencies presently in the field will almost certainly force the emergence of new and better patterns. One of these patterns, if we build soundly, will be to bring to workers in industry the elements of preventive medicine. Through prevention we will lessen the burden on our curative facilities and at the same time improve individual effectiveness, thereby increasing our productive ability as a nation.

You are familiar with the booklet "The Nation's Health-A Ten Year Program" which is Social Security Administrator Ewing's blueprint for bringing better medical care to all of the people. I quote briefly from page 98 where he explains how

"Beginning with the effective date, three years after enactment of legislation, insured persons and their dependents would obtain health and

his plan is going to be worked out:-

medical services they need up to the capacity of the personnel and facilities existing at the time and the limits of local availability. Strong efforts during the tooling up period will assure more personnel and facilities in many areas than is possible today. There would, however, be less service in many places during these first years than there will be available later when resources and services have been further increased.

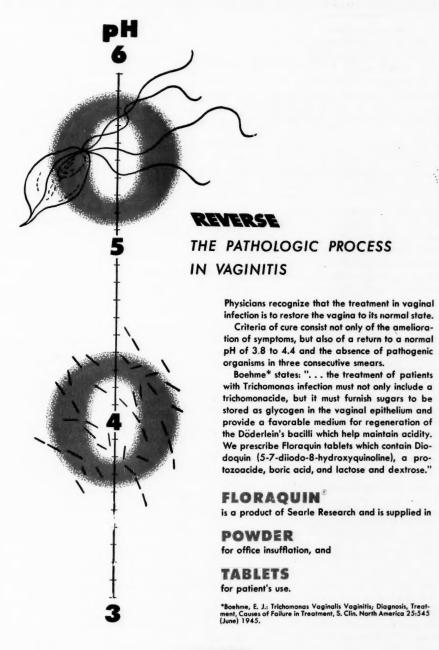
"The total number of persons covered in the United States by health insurance will depend on the terms of the basic legislation. If the law were enacted at once, and coverage made identical with that of the present Old Age and Survivors Insurance system, benefits would be available to some eighty-five million persons, counting insured workers and their dependents-a little more than 60% of the population. When Old Age and Survivors Insurance is expanded to cover groups not now included, a matching expansion of health insurance could cover between 120 million and 130 million people—nearly 90% of the population. The ultimate goal is that every person-100% of the population-should be eligible for insurance benefits."

Should Mr. Ewing's law be enacted at once,then, he promises that three years from now benefits would be available to 60% of the population.

Did you know that in New England today, 57.5% of the population already has insurance protection against the cost of hospital care? In the field of hospitalization in New England we have already come a long way towards achieving the goal established by the proponents of an all-inclusive federal scheme. Twice as many people in New England now have hospital insurance protection as are covered under the compulsory unemployment compensation insurance laws created by the Social Security Act of 1935.

Breaking our estimates down by state, we find that Rhode Island, as many of you know, is the leader not only in New England, but in the United States, with 83.7% of the population covered for the costs of hospitalization. Massachusetts comes next with 60.1%, followed by Connecticut with 56.8%, Vermont with 46.0%, New Hampshire with 42.2%, and Maine with 37.3% for an overall New England total, as I just stated, of 57.5%. This is a better showing for New England than the country continued on page 274

^{*}Presented at a meeting sponsored by the Council of the New England State Medical Societies, at Boston, Massachusetts, March 27, 1949.



SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

EXTENDING MEDICAL CARE IN NEW ENGLAND continued from page 272

as a whole, where the figures show that 52½ million people have hospital insurance, or 36% of the total number. 52½ million people presently covered, however, is not so far from Mr. Ewing's goal. Given three years at the present rate of growth, hospitalization coverage would almost certainly achieve it. Study of the figures reveals that in Rhode Island and also Vermont we have already passed it.

For New England, the figures indicate that approximately 1,700,000 people have hospitalization insurance under insurance company plans and about 3.600.000 under Blue Cross Insurance Plans. I know of no one in the insurance industry who would dispute the outstanding achievement of Blue Cross both with respect to the number of people insured and the low administrative cost of their operation. Insurance companies seek only the privilege of continuing to compete with Blue Cross for customers on the basis of price and service in comparison with theirs. This does not mean that insurance companies would not be disturbed if Blue Cross subscribers were to receive preferential treatment over insurance company policyholders from hospital authorities, public authorities or medical authorities. Preferential treatment, tending to monopoly is as much against the public interest in this field as in industry. Insurance wishes to see no monopoly of any kind-public or private. Both Blue Cross and insurance companies are needed if the required volume of coverage is to be furnished. Both types of organization should be allowed to compete side by side without special concessions to the one or the other. Under these conditions hospitalization insurance will be made available to the greatest number of people at the lowest cost.

Prepaid Surgical Insurance

That hospitalization insurance cushions the financial impact of catastrophic illness no one can deny, but there is also the surgeon's bill to meet. In New England some 2,300,000 people have protected themselves against the cost of surgical or obstetrical care: 200,000 by individual insurance policies, 650,000 employees and 450,000 dependents under group insurance policies, approximately 800,000 people under Massachusetts Blue Shield, and an estimated 200,000 by the New Hampshire, Vermont and Connecticut "Blue" plans. Surgical and obstetrical expense insurance now covers about 20% of the people in New England. Taking the United States as a whole it is estimated that over 26 million people have such protection.

The newest comer to the field of health insurance is protection against the costs of doctor's care in the hospital, office and home. Although this coverage was practically non-existent up to one or two

years ago we now find about 154,000 people with such comprehensive protection in New England and about 2 million people countrywide.

I have told you that twice as many people in New England now have hospitalization insurance protection today as the number covered by the unemployment compensation laws passed in 1935. The number of people voluntarily protected today compares favorably with the number Mr. Ewing seeks to protect by compulsory federal legislation after a three year tooling-up period. (79.6% for New England)

Cash Sickness Compensation

In view of the fact that the Administration program also contemplates what has come to be known as "cash sickness benefits" it is interesting to compare what insurance has been able to accomplish in the field of income replacement by weekly indemnity benefits for time loss due to sickness. Since the question of dependents is not involved, we have a direct comparison of the number of people so covered with the number covered under the Social Security laws presently in effect. In this connection, may I point out the fact that insurance companies have found a greater public demand—less buyer resistance—for income replacement insurance than for medical insurance. The typical employee is more concerned to insure his loss of earnings than he is to buy hospital and surgical coverage. This is because he has a tendency to think of his family, first, and believes that somehow his medical needs will be taken care of.

As you know, Rhode Island already has a Compulsory Cash Sickness benefits law which provides such benefits to all employees covered under Unemployment Compensation, so that 100% of the workers in Rhode Island necessarily are covered. In addition about 30,000 physicians, dentists, salesmen and other independent contractors have purchased individual insurance policies so that in Rhode Island more people have income protection than are covered by Unemployment Compensation. The other New England states do not have Compulsory laws although in Massachusetts and Connecticut at the present time there are serious legislative proposals for compulsory laws.

Let us compare the extent of this voluntary weekly indemnity insurance coverage with the number of people covered under the Unemployment Compensation laws. Taking group insurance alone it runs approximately 33%, but if we add also the individual policies providing for loss of income, paid sick leave, employee mutual benefit association plans and other employer-employee methods, we get a surprising result. We find that in both Maine and Vermont, as well as Rhode Island, more people currently have income protection than are compulsorily covered by the Unemcontinued on page 276

Why Many Physicians Write It CARSTAIRS

when whiskey is indicated

MORE and more well-informed physicians are recommending light blended whiskey to their patients when whiskey is medically indicated. Reason:

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Medical
The Man who Cares says

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EXTENDING MEDICAL CARE IN NEW ENGLAND continued from page 274

ployment laws. In New Hampshire 94.4%, Connecticut 85.9% and Massachusetts 76.2% as many people have some kind of protection against loss of income through sickness as are presently in the Unemployment Compensation system. Taking New England as a whole, 2,300,000 people now have some kind of protection against loss of earnings arising as a result of sickness. This compares with 2,600,000 employees covered by Social Security.

The figures I have cited prove that voluntary insurance has done quite a job in extending coverage to a very substantial segment of the total population, both with respect to hospitalization and in the field of income replacement due to sickness.

What has been done compares favorably with what the proponenets hope to achieve through legislative fiat. Competitive insurance has the experience, facilities, and resources to design, administer and finance continued progress not only in New England but also countrywide. Experience in New Jersey and California where the legislatures have determined on a "cash sickness" program comparable to Rhode Island, but where competitive insurance has the right to operate along side the state instrumentality, proves that private insurance is equipped to handle the coverage even under such conditions. Indeed there are many of us who insist that it is not necessary for the state to engage in the insurance business at all.

The Rhode Island Plan

Later on the program, Dr. Swett and Dr. Farrell will discuss the Maine and Rhode Island Surgical Care plans with you quite fully. It was my privilege, together with other representative insurance men, to work closely with both Dr. Swett and Dr. Farrell and with the other doctors appointed to the Maine and Rhode Island Health Insurance Committees.

The Maine and Rhode Island plans are similar in character. Under the plans, insured individuals in the eligible income group are guaranteed "payment in full" for surgery and obstetrics, including the usual pre- and post-operative hospital care. In both states, the percentage of practicing physicians agreeing to participate under the plans has been very encouraging. I have discussed the fundamentals of the Maine and Rhode Island plans with a number of disinterested people who have studied the problems involved in prepayment medical care, and all of them have told me that these plans are fundamentally sound.

It is perhaps too early to tell how much success these Plans will ultimately have. Those of us who have worked to help create the Plans feel that they meet a real need, that they can be made attractive to the public and that they contain the fundamental elements of success both from a medical and from an insurance point of view. They contradict Ewing's assertion that voluntary insurance on an indemnity basis cannot provide for "payment in full."

In our economy, however, the consumer is the one who determines the ultimate success or failure of the commodity or service we sell. Experience shows that some of those who most seriously demand changes in existing medical institutions and practices are unwilling to back an insurance plan requiring a premium payment commensurate with the cost of the service rendered. Many of these people have clearly indicated that they want something for nothing. It is impossible to design a sound insurance plan that will give people something for nothing. The only way to give people something for nothing is through the tax system, although over-all the taxes must be paid for by the people. An insurance system is the exact opposite from a tax system, and it is something less than honest to try to sell a tax system by calling it an insurance system. Please do not misunderstand me. I do not deny the need for a tax system to support the relatively few unfortunates who cannot afford to pay their own way, but I do deny that an all-inclusive insurance system should be created by government simply to provide for them.

With your permission may I take the remaining few minutes to set forth as briefly as I can a background of thinking, which if implemented, would go a long ways further towards reaching our National Health goals than a uniform compulsory system can possibly achieve.

Industrial Management Challenged

Destiny has placed our lifetimes squarely in a cycle of world-wide rapid, revolutionary change. We see and feel the spirit and effect of change at every hand. The whole philosophy of industrial management has been challenged. Taxes are used not only as a revenue source but to produce social reforms, seeking to achieve a leveling of incomes. Because all established institutions have been under attack in one way or another, it is not surprising that the medical profession has also been called upon to answer for and to defend its conduct. In this we have a mutuality of interest. As you know, the insurance business is not immune from attack either. But we must realize that much of this restlessness, this demand for change, is creative. We live in an age when, as a result of our democratic institutions, our educational processes and our system of mass communication, people want to be recognized as responsible human beings. People who devote a large part of their lives to the factory in which they are employed, or the business with which they are associated, want to be more than cogs in a machine. They want to share the risks continued on page 278





PREPARATIONS: Schering steroid hormones-Progynon* (Estradiol U.S.P. XIII), PROLUTON* (Progesterone U.S.P. XIII), ORETON* (Testosterone Propionate U.S.P. XIII) and CORTATE* (Desoxycorticosterone Acetate U.S.P. XIII), prepared in tablets for buccal administration, and dissolved in a

newly developed solvent, Polyhydrol t

RESULTS: Weight for weight, absorption of steroid hormones in POLYHYDROL from buccal and gingival mucosae is far superior to ingestion and compares very favorably with intramuscular injection. The clinical response is consequently excellent.

ADVANTAGES: The administration of Buccal Tablets of PROGYNON, PROLUTON, ORETON, and CORTATE is (1) convenient, since injections are avoided; (2) simple, because of the new solid solvent; and (3) economical, because of the enhanced utilization of hormone.

ADMINISTRATION: Buccal tablets are not swallowed, but placed in the buccal space, between the gum and the cheek, whence they are absorbed directly into the systemic venous circulation.

RATIONALE: Utilization of the systemic venous return by way of the capillaries and veins of the mouth, tongue, pharynx and upper esophagus, circumvents some hepatic inactivation which follows ingestion.

PACKAGING:

PROGYNON Buccal Tablets 0.125 and 0.25 mg. • PROLUTON Buccal Tablets 10 mg. • ORETON Buccal Tablets 2.5 and 5 mg. • CORTATE Buccal Tablets 2 mg. *R POLYHYDROL trade-mark of Schering Corporation

CORPORATION
BLOOMFIELD, N. J.
To Canada, Schering Corporation Limited, Montreal

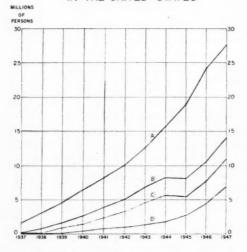
EXTENDING MEDICAL CARE IN NEW ENGLAND continued from page 276

and rewards. They want to participate in the decisions which affect themselves and their fellows.

We cannot prevent this cycle of change, nor would it be desirable for us to try to do so if we could. Our efforts should be to channel change in directions which will achieve the goal of improved living conditions. These attacks have been directed on good and bad institutions alike. Perhaps they have resulted from our failure to convince enough people of the values inherent in our democratic, competitive enterprise institutions. To preserve these values people have to believe in them. We must counteract the impression that labor and management are working against the interest of one another. We must find a way to make people understand that only by working together can they produce more and provide more for everyone. Our American economic system, the American way of life, if you will, has never been and doubtless never will be static. It is a vital, moving, dynamic force and if our established institutions are to continue to serve the people they must always be alert to needed improvements, keeping them abreast to the pattern of change. This is as true of medicine as it is of insurance and business generally. We threaten what we seek to preserve if we blindly defend the status quo.

What I am saying is that fundamentally we are dealing with something more important than the

GROWTH OF VOLUNTARY HOSPITAL AND SURGICAL INSURANCE IN THE UNITED STATES



- A BLUE CROSS HOSPITAL EXPENSE
- B GROUP INSURANCE HOSPITAL EXPENSE
- C GROUP INSURANCE SURGICAL EXPENSE
- D) "BLUE SHIELD" SURGICAL EXPENSE

mechanics of devising a method to spread the costs of medical care. What we are really dealing with is the significance of medicine as it relates to the effectiveness of the individual, to industry, the public health and the national economy.

We are engaged in a contest between those who hold that only compulsory provision, preferably by the federal government, can adequately meet the need for medical care and those who maintain that the inevitable outcome of such a development would be an overall decline in the quality and effectiveness of medicine. But we who believe in the competitive system have to do more than oppose change. In the final analysis, our ultimate goal is really the same as Mr. Ewing's. We want to keep America strong. We want to keep the nation strong by achieving for the American people the good health necessary for the fullest production of goods and services.

How can we achieve this goal?

First, there must be adequate medical care and facilities for all the people. No one disputes the fact that medical care has a higher standard in the United States than in any country of the world. This is not to deny that certain nations such as Sweden and Denmark may spread their medical care more evenly than we do. Our problem, therefore, becomes how to devise workable methods to spread medical care more widely without damaging the high standards we have already achieved, and in such a way as to maintain our fullest productive energies.

Number of Alternatives

It is at this point (see page 89 of "The Nation's Health") that Mr. Ewing asserts that voluntary insurance plans cannot do the job that has to be done so that he says there are only two alternatives: either a method of prepaid government health insurance or to go ahead as we have in the past. Mr. Ewing says that to go ahead as we have in the past is not good enough and I, for one, would be prepared to accept his point. I cannot, however, accept his statement that there are only two alternatives. There are a number of alternatives. You doctors know, so I do not need to take the time to tell you, but I think it is up to you to tell the people, that Ewing's proposal is the least desirable of the alternatives. It is the least desirable because it will not improve the health of the people. It is the least desirable because it will damage rather than improve the productive energies of the people. These facts are well known to all who have studied the experience of the various foreign countries with nationalized sickness insurance. A doctor who was delegated to find out whether the increased frequency and duration of illness following the introduction of national health insurance was real or continued on page 284

description

Smooth, refreshing, chocolate-mint-flavored suspension of nontoxic SULFASUXIDINE® succinylsulfathiazole (95% retained in bowel), 10%; Pectin, 1%; and Kaolin, 10%. Particularly well accepted by infants and children. Toxicity is negligible.

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Infants: 2-3 teaspoonfuls, 4 times daily. Children: 1-2 tablespoonfuls, 4 times daily. Adults: 2-3 tablespoonfuls, 4 times daily. Supplied in 16 fl. oz. Spasaver® bottles. Sharp & Dohme, Philadelphia 1, Pa.



DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual business meeting of the Pawtucket Medical Association was held on March 17, 1949, at noon in the Nurses' Auditorium of Memorial Hospital. Twenty members were present.

The meeting was called to order by the President, Dr. Earl J. Mara and at his request the Secretary read the minutes of the previous meeting, the minutes of the preceding annual meeting, the list of all active, associate and honorary members, and the annual report of the Secretary. There were no corrections.

The report of the Treasurer was read and accepted.

Dr. Mara delivered the President's annual address stressing his usual theme of attendance at Medical Meetings so that actions of the Delegates to the Rhode Island Medical Society may be representative of at least 50 per cent of the group.

The action of the Caduceus Club regarding emergency Medical Coverage was discussed and it was voted that the Secretary have printed a card to be inserted with the yearly bill for dues, inscribed as follows: The Caduceus Club has gone on record as favoring an emergency call panel. Would you be willing to participate in such a plan?

On a motion by Dr. Fox, seconded and unanimously passed the secretary was instructed to cast one ballot for the entire slate nominated by the Nominating Committee.

The following officers were elected for the com-

ing year.	
President	Dr. John H. Gordon
Vice President	DR. JAMES P. HEALEY
Treasurer	DR. LAURENCE A. SENSEMAN
Secretary	DR. K. WILLIAM HENNESSEY
Counsilor	DR. CHARLES L. FARRELL
Delegates	Dr. Earl Mara
	Dr. J. LINCOLN TURNER
	Dr. Robert T. Henry
	Dr. Henry J. Hanley

The new President, Dr. John H. Gordon, was then escorted to the dais and adjourned the meeting to March 29, 1949, at 7:30 p.m. in Brook Manor, North Attleboro for the annual dinner.

Forty-nine members and guests attended the dinner.

Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society brought greetings from the State Society.

Dr. Earl Kelly presided as Master of Ceremonies. Entertainment was provided by a pantomine artist, who was ably assisted during one interlude by Drs. Henry Hanley, James Chapman and Armand Bertini.

The meeting adjourned at 10:30 p.m.

Respectfully submitted,

K. W. HENNESSEY, M.D., Secretary.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 4, 1949. In the absence of Dr. George W. Waterman, President, the meeting was called to order by Dr. U. E. Zambarano, Vice President of the Association.

Dr. Daniel V. Troppoli read the minutes of the previous meeting which were accepted as read and placed on file.

Dr. Troppoli reported that the Association was conducting its Prize Case Report Contest in 1949 for the best report of a clinical case or series of cases submitted by a house officer or resident in one of the local hospitals. He urged members to encourage young physicians to participate in this contest.

Dr. Troppoli also discussed communications he had received from the office of the Secretary of Defense in Washington regarding the critical need for physicians for the armed forces. He reported that there was indication that if these needs were not met, a draft of physicians would be necessary. Dr. Jacob Kelly moved that the Association communicate with the young physicians in the Providence county area who received all or part of their medical education at the expense of the Government in V-12 or ASTP programs, and who have not served on active duty as medical officers with the armed forces, to urge them to consider enlistment in one of the branches of military service to meet the physician need.

The motion was seconded and adopted.

Dr. Zambarano presented as the first speaker of the evening, Dr. John T. Barrett, Senior Resident, continued on page 282



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RHODE ISLAND MEDICAL JOURNAL

PROVIDENCE MEDICAL ASSOCIATION

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Department of Pediatrics, R. I. Hospital who discussed a paper prepared by Dr. Stanley S. Freedman, Associate Physician, Department of Pediatrics, R. I. Hospital, and him, on "KAPOSI'S VARICELLIFORM ERUPTION".

Dr. Barrett depicted this condition as a modification of infantile eczema, since it occurs exclusively in eczematous children. He then presented the history of an eight month old baby that presented this condition together with illustrative lantern slides. The temperature ranges from 101 to 105, and the skin lesions may last eight to twelve days. Restlessness, nausea, vomiting, and diarrhea with intense pruritis are the main symptoms. The lesions are discreet, one to two mm. in diameter, they appear in crops, may become umbilicated, and contain clear fluid except when infected. Occasionally they coalesce and rupture to form raw bleeding surfaces, particularly in the folds of the body. After a few weeks, the lesions disappear leaving the original eczema. Fatalities do occur. In New York, three weeks after mass small pox inoculations, forty-three children developed the disease of whom two died.

The etiology is unknown. Some men believe the virus of vaccinia is the agent, others that it is the virus of herpes simplex.

The second speaker of the evening was Dr. J. Murray Beardsley who presented "RECENT TRENDS IN SURGERY OF THE THORAX".

Dr. Beardsley reviewed the rapid strides chest surgery made in the last few years. Now a complete thoracic esophagectomy with restoration of continuity can be done. The lower one third is a common procedure. Diaphragmatic hernias are repaired as easily as simple herniae. All general surgeons can use the thoracic approach for splenectomy or spleno-renal anastomosis. Also, surgery of congenital heart deformities use the thoracic cage for approach.

The thoracic clinic is a great help in treating cases—here the opinions of the internist, radiologists, and surgeon are pooled. Last year, patients made 500 to 600 clinic visits at Rhode Island Hospital.

Since the introduction of antibiotics, acute empyema has become rare. The aim of treatment in empyema is disinfection of the pleural cavity, and reexpansion of the lung. The treatment of empyema by aspiration and introduction of antibiotics has its place, but there are certain contraindications viz multiloculated fluid spaces, anaerobic organisms, and broncho-pleural fistulas. Dr. Beardsley prefers a catheter in the chest which allows irrigation, introduction of antibiotics, and suction for reexpan-

sion of the lung. The open method is the best method. The only objection to it is that it takes longer, since the cavity is exposed to the air.

In lung abscess, as in true expyema, non operative methods must be used with caution. Early drainage is superior to all other methods since suppuration here demands early drainage, otherwise you get spread of the disease or a chronic stage.

A chronic abscess that is drained may lead to fibrosis, therefore, a lobectomy is recommended for this. The mortality rate is only 5 per cent in these cases. Many may be lost because of spread of the disease and may never get to surgery if this is not done. Bronchoscopy is used routinely in every case.

Surgical treatment of bronchectasis reduces mortality and eliminates complications. Antibiotics, improvements in anesthesia, the use of segmental dissection instead of mass ligation, all have led to reduced hospital stay and reduced mortality in this condition. Now they remain in the hospital only one to two weeks. Five years ago the mortality was 75 per cent. At present it is 35 per cent.

Routine chest plates will detect more carcinomas of the lung. If a doubt exists, an exploratory thoracotomy should be done. Many carcinomas of the lung show up as lung abscesses. In all cases of lung abscesses in the older age group carcinoma is suspected.

In the peripheral cases where the lesion is beyond the reach of the bronchoscopist, an exploratory should be done. Cytological examination of the sputum is an additional help in diagnosis. Considerable experience is necessary in this method. It is useful in cases where actual biopsies cannot be obtained.

There is now a change in attitude of carcinoma that involves the ribs. Some of these are now found to be more favorable than lesions situated in main stem bronchi. Peripheral lesions may have pain as a symptom since they are locally invasive in some instances. In resections of the chest wall, tantalum plates are used which are removed after a few weeks. This creates a firm membrane. In a few cases of undifferentiated carcinoms, nitrogen mustard has been used, since these respond to this treatment.

The paper was discussed by Drs. Windsberg, Ham, De Wolf, and Peter Chase.

The meeting adjourned at 10:35 p.m. Attendance 62.

Collation was served.

Respectfully submitted,
Daniel V. Troppoli, M.D., Secretary.



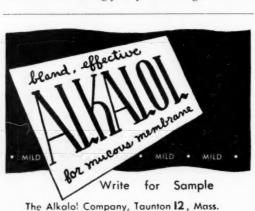
EXTENDING MEDICAL CARE IN NEW ENGLAND continued from page 278

only a species of malingering succinctly summarized the experience by his statement: "The individuals are really ill, but strange to say, they would be well if the law were not in existence." (Strow p. 22)

As I have said, the number of alternatives is not limited to only two. There are many. If government does not pre-empt the field for itself, they will emerge as a result of the continued competition of the several agencies already in existence. One of these alternatives, I think you will agree, holds much promise. It is not a panacea. It will not work itself out overnight, it will not come by legislative decree. But it has already been tried on a limited scale and good results have been achieved.

In our country we have a working population of 60 odd million people. Therefore, we must recognize that the worker is a paramount influence on what is done about the health of America. We know that many forward-looking employers by working closely with the medical advisors have been able to improve the health of their people not only on the job, but also have improved the health of the employees' families and bettered their home environments. Industry, therefore, has compelling reasons and a ready-made organization to develop programs for health improvement, a community of interest not shared by any other agency.

For many years the workmen's compensation insurance carriers have worked directly with industry to prevent losses arising out of industrial accidents. Workmen's compensation laws make the cost of accidents a cost of producing goods. Competition between producers of goods forces them to keep costs of production as low as possible. The cost of workmen's compensation insurance can be reduced by not having accidents. As a result, employers have become directly interested in preventing accidents and increasingly they have bought their in-



surance from the companies that in their judgment could help them the most in preventing accidents. As a result intensive competition has arisen between insurance carriers to develop the most effective loss prevention facilities to help employers. This competition has produced remarkable records. For example, in 1913 the first full year of the Massachusetts Workmen's Compensation system 474 men and women were killed in Massachusetts industries. In 1948, with 50% more people employed in our industries, there were 213 fatalities. That is a reduction from over 50 deaths per hundred thousand workers to 13 per hundred thousand, a 72% reduction.

Importance of Industrial Medicine

From our work in industrial safety we know that to make future improvements as spectacular as our past achievement requires increasing emphasis on personal causes of accidents. These personal causes include bodily incapacity, improper placement, lack of adjustment on the job and emotional upsets. Personal causes are outside the field of the safety engineer who deals with machine guards, plant layouts and supervisory methods. Personal causes of accidents involve the physical abilities of people to handle their work and are directly a part of the field of medicine. Therefore, to accomplish a satisfactory reduction in accidents arising from personal causes we must seek the assistance of industrial medicine.

Now we find that physicians have learned to relate the worker's environment to the demands of his job. They can teach the cardiac the importance of working and playing within his reserve. They can teach the diabetic the necessity of dietary discretion and continuing medical check-ups. They can recommend modifications in the job relationship if the work demands too much of the joints or the heart. The physician is the one who can recognize the early symptoms before disabling pathology results, can recommend better work and play habits, better personal hygiene and better nutrition. Hence, the physician is in the key position to increase the individual effectiveness of workers.

By individual effectiveness we mean the ability of a person to perform well in his chosen occupation, without harm to himself, and to live well in his environment outside the plant. Individual effectiveness is the sum of all the factors that affect the man's productive capacity; it means good health in relation to his work. If we can successfully increase individual effectiveness, we will not only continue the gains we have made in accident prevention, but we will go a long way towards placing our industrial economy on a sounder and more productive basis. Employed people and their dependents are the nation. By working with them in their shops, we have the most practical solution for improving

ESTIMATED NUMBER OF PEOPLE WITH HEALTH INSURANCE PROTECTION IN NEW ENGLAND

	MAINE	NEW HAMPSHIRE	VERMONT	MASS.	RHODE	CONN.	TOTAL NEW ENGLAND	TOTAL UNITED STATES	% N. I IS O U.S.
7/1/48 POPULATION	900,000	548,000	374,000	4,718,000	748,000	2,011,000	9,299,000	146,000,000	6.4
3/48 COVERED II	NDIVIDUAL	S UNDER	UNEMPL	OYMENT	COMPENSA	TION (SOC	CIAL SECUE	RITY) LAW	S∶-
	169,109	127, 138	62,011	1,447,239	242,877	638,017	2,686,391	33,250,000	8.1
% SOCIAL	SECURIT	Y COVER	AGE TO	TOTAL					
POPULATION	18.8	23.2	16.6	30.7	32.5	31.7	28.9	22.8	
EWING IM	MEDIATE	GOAL -	I COVERED	INDIVID	UALS TI	MES 2	-		
	420,000	315,000	155,000	3,618,000	607,000	1,595,000	6,710,000	85,000,000	
HOSPITAL	INSUR	ANCE -	FSTIMATE	D NUMBI	FR OF PE	OPLE CO	VERED -	1947	
INSURANCE COMP									
INDIVIDUAL POLICIES	31,000	20,000	17,000	144,000	19,000	77,000	308,000		
GROUP -EMPLOYEES	46,000	34,000	28,000	369,000	51,000	175,000	703,000		
DEPENDENTS	46,000	34,000	28,000	370,000	51,000	175,000	704,000		
BLUE CROSS PLANS	212,000	142,000	97,000	1,953,000	504,000	715,000	3,623,000		
TOTAL	335,000	230,000	170,000 TOOES NOT INC	2,836,000	625,000 COVERED BY	1,142,000 OTHER AGENCIE	5,338,000	48,809,000	10.9
% TO EWING GOAL	79.8	73.0	109.7	78.4	103.0	71.6	79.6	57.4	
SURGICAL	EXPE	NSE	INSUR	ANCE					
INSURANCE CO'S - TOTAL	91,000	67,000	56,000	671,000	92,000	324,000	1,301,000	15,338,000	8.5
MEDICAL	EXPEN	SE INS	URANC	E					
INSURANCE CO'S -	11,000	8,000	7,000	78,000	11,000	38,000	153,000	2,069,000	7.4
LOSS OF	NCOME	(SIC	KNESS'	COMPE	NSATIO	ON INS	URANC	E)	
INSURANCE COMP	PANIES								
NDIVIDUAL POLICIES	48,000	31,000	27,000	224,000	30,000	121,000	481,000		
GROUP POLICIES	55,000	41,000	34,000	438,000	242,877	208,000	1,018,877		
AID SICK LEAVE, ETC	69,000	48,000	40,000	441,000	_ 0	219,000	817,000		
TOTAL	172,000	120,000	101,000		272,877	548,000		31,224,000	7.4
% THOSE CO	VERED U	NDER GRO	UP INSUR	PANCE IS	TO NUM	BER OF	COVERED	INDIVIDUA	LS
	32.5	32.2	54.8	30.3	100.0	32.6	37.9		
% THOSE W		OME PRO			NG GROU	P INSUR	ANCE) IS	TO NUM	BER
	101.7	94.4	162.9	76.2	112.4	85.9	86.2	93.9	

the national health. The most practical way to increase the individual's effectiveness is to give him the chance to maintain his health through making facilities available for him in well-organized and well-administered industrial plants.

The medical profession can improve the health of the nation if it will team up with industry which is itself dependent on the nation's health. Doctors

can find a common ground with industry on which to sow the seeds of improved employee health. Industrial medicine—preventive in purpose—is the common ground. Group insurance of the gainfully employed has proved its economic desirability. Extension of the coverage to broader benefits, if accompanied by provision for facilities to reduce losses through preventive medicine, can be accom-

continued on next page

EXTENDING MEDICAL CARE IN NEW ENGLAND concluded from preceding page

plished at costs that are not prohibitive. The need is for more preventive medicine so that individuals not only conserve their health but improve it. This is the positive approach. The value of the positive program is two-fold: it will not only promote better health maintenance for individuals, it will also make a definite contribution to our nation's ability to produce because it will increase the effectiveness of the worker. By increasing individual effectiveness, it will improve the worker's earning ability; that is, his standard of living. Family, community and social life will be healthier and happier. From our work in the field of plant safety, we know that all over America there are industries ready and anxious to go ahead with broad, constructive inplant health programs. They must have the active participation of the medical profession.

By working with industry physicians will translate their physical findings into work capacity and work limitations and to begin individual guidance towards constructive health. They will relate the environment and the demands of the job to the health of the worker. They will have a chance to recognize early symptoms and to teach employees the importance of early and adequate care to prevent disability, hospitalization and surgery, thus lessening the burden on curative facilities. They will help management to understand the importance of employees' health, so that the philosophy of preventive machine maintenance will be carried over and made applicable to preventive human maintenance through the development of employee health programs.

By handling health maintenance at the plant level we will achieve not only better health but better employee effectiveness that will result in more efficient production. Health maintenance, coupled with adequate insurance for catastrophic illness to the employee or his dependents, will achieve within the competitive enterprise system the ultimate health goals of the nation.

Let us achieve these goals by continued forward progress along a broad front; by further experimentation with the many alternatives that will be forthcoming in a dynamic, competitive society; building upon, rather than tearing down, the strong foundations that we already have in medicine, insurance and industry.



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Iron (as proteinate)50	mg.
Folic Acid 5	mg.

HEMABOLOIDS with

Liver Concentrate

Each fluid ounce represents:	
Alcohol (by volume)	.17%
fron (as proteinate)	
Liver Concentrate (20:1)	.500 mg
Cane sugar, alycerine, flavoringaa	q.s.

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with Liver Concentrate

Each tablet represents:						
Iron (as proteinate)	 				35	mg.
Liver Concentrate (20:1)	 				100	mg.

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Each fluid ounce represents:	
Alcohol (by volume)	.17%
Arsenous Acid	. 1/20 gr.
Iron (as proteinate)	.120 mg-
Cane sugar, glycerine, flavoringaa	

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Allergic Disorders
Irritability
To combat stimulation of
ephedrine alone, etc.3,1

Irritability Associated
With Infections⁴
Restlessness and Irritabili

Restlessness and irritability With Pain^{5,4} Central Nervous System

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Tetanus
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'Nembutal and Balladonna,
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'Nembudeine®,
'Nembutal and Aspirin,

CASH SICKNESS CLAIMS PROCEDURE REVISED TO STRENGTHEN SYSTEM

—Reprinted from the Monthly Bulletin, Vol. II, No. 11, March, 1949, of the Department of Employment Security, State of Rhode Island. . . .

This month Rhode Island will initiate revisions in its procedures for handling Cash Sickness Compensation claims which are designed to strengthen the administrative control of such claims and eliminate the possibility of claimants collecting benefits fraudulently. The revisions and the separation of the claim form, which heretofore has been signed by both the claimant and his physician at the same time, into two separate forms is expected to simplify things both for the claimant and his physician.

Because the claimant no longer has access to the medical statement, the physician will be able, under the new system, to give more detailed medical diagnosis and prognosis on his report, which will be reviewed only by the Medical Director of the Cash Sickness Division and not by the claimant. In many cases, such as cancer, physicians have been reluctant to enter an exact diagnosis on the form which has been in use, because of the fact that patients could see their remarks.

As far as the Cash Sickness claimant is concerned, the new procedure will make it possible for him to obtain an initial application for sickness benefits as soon as any injury or sickness occurs which he feels will cause him to lose at least seven consecutive days of employment, and mail the application to the Sickness Benefits Division without making a special visit to have any form completed by a physician. Cash Sickness claimants are also relieved of the necessity to report for physical examination by physicians at the offices of the Unemployment Compensation Board.

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Certification by attending physicians, which is the backbone of the whole Cash Sickness Insurance program, will be strengthened considerably by the new system which places greater responsibility upon doctors by requiring them to give more detailed medical information on the separate form which they will now have to fill out. The use of this new medical report is expected to reduce the number of claimants ordered to appear for physical examination and will eliminate entirely the present system of the Board employing physicians on a part-time basis for these examinations. Hereafter, if the Board desires a further check on the physical condition of a claimant, he will be sent to a private practitioner in his own community, selected from a list submitted by the R. I. Medical Society and paid by the Board.

Incorporated into the new procedure is provision for a staff of field visitors who will conduct scheduled as well as unscheduled visits to workers receiving sickness benefits. The purpose of these visits will be to obtain certain data, other than medical, to assist the Medical Director of the Cash Sickness Division in adjudicating claims for cash sickness benefits.

If a claimant is still ill and unable to return to work at the end of the estimated period originally given on his claim, the attending physician will be asked for a supplementary statement with further medical information. The whole case will then be reviewed by the medical director to determine whether there is sufficient medical evidence to substantiate an extension of the claim. If the medical director does not consider an extension warranted, the claimant will then be referred to another physician for examination at the expense of the Board. Appeals tribunals to hear claims in which the claimants are dissatisfied with the UCB decisions will consist of representatives of the medical profession.

All features of the revision in procedures and all of the new forms necessitated by them were the result of months of study by the Unemployment Compensation Board and its staff in consultation with a special committee of the Rhode Island Medical Society. The medical society will furnish to UCB a list of doctors willing to conduct further examination of patients where differences of opin-

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ion occur and where the medical information supplied by the attending physician does not appear consistent with his recommendation on the expected duration of the claimant's inability to work.

PHYSICIANS FOR ARMED FORCES

A direct appeal is now being made to the 8,000 young physicians and dentists who were trained at government expense under the wartime Army Specialized Training Program and the Navy V-12 program, and who have given little or no service to the Armed Forces, to volunteer for active duty in one of the three Armed Services.

An appeal is also being directed to the 7,000 physicians and dentists who were deferred during the war to complete their medical or dental educations at their own expense, and who have not served in the Armed Forces, to volunteer for active duty.

This program is a joint undertaking of the three Services, the American Medical Association, the American Dental Association, and other allied professional groups to fill the critical professional manpower shortage which faces the Armed Forces. Local professional groups are being furnished the names of the physicians and dentists in their particular communities who received professional training at government expense, and are asked to contact these men for personal interviews to inform them regarding the critical needs of the Armed Forces. They are asked to make regular reports to the Secretary of Defense on the result of the interviews.

Secretary of Defense James Forrestal said that by the end of July of this year, the Armed Forces will have lost almost one-third of the present number of physicians and dentists now in service. This will result in a shortage of about 1600 physicians and 1160 dentists. If this condition is allowed to develop the number will have increased to 2200 physicians and 1400 dentists by December.

Normal procurement procedure for professional replacements can not hope to supply the requirements for the Armed Forces. For example, during the month of January, 1949, only 30 physicians and 20 dentists were commissioned in the Armed Forces.

Should a shortage of professional manpower be allowed to materialize it could easily jeopardize the whole National Defense Program. It would mean the Armed Forces would not have enough physicians and dentists to furnish even a minimum of medical and dental service to the nearly 2,000,000 men and women in the military Services.

It is estimated that the government expended almost \$10,000,000 to educate, feed and clothe the 8,000 men who participated in the wartime programs.

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PRIZE CASE REPORT CONTEST — 1949

THE PROVIDENCE MEDICAL ASSOCIATION offers vearly a first prize of \$50.00 and a second prize of \$25.00 for the best report of a clinical case, or series of cases, submitted by a house officer or resident in one of the local hospitals and presented by him before a regular meeting of the Association, subject to the following conditions:

(1) The case, or series of cases, must have been studied by the contestant during his hospital service.

(2) The manuscript must be endorsed by the visiting man under whom the work was performed. This endorsement consists merely of a statement that the work described in the report was done on his service. The statement will be enclosed in a sealed envelope containing the name of the contestant. On the outside of the envelope will be placed a number, letter or motto which will be written in the same manner on the manuscript in place of the author's name.

(3) The manuscript must be typewritten and submitted in duplicate to the Executive Secretary of the Providence Medical Association during the hospital service of the contestant or within six

SUCTION SOCKETS



Artificial legs without hampering straps have been the shining hope of amputees. Recently, the development of the Suction Socket Leg for above knee amputees seemed to realize this hope.

We understood what this type of limb could mean to the amputee. But we knew that these limbs were not perfected, Thus, in 1947, we joined with the Committee on Artificial Limbs and the VA in a program of research on the Suction Socket Limb. Under this program veteran cases have been awarded by the VA to companies having certified suction socket fitters. To date we have fitted well over 100 suction socket cases, of which 90% have been satisfactory

Results of research show only about 20% of cases suitable for suction sockets. Results also show that close cooperation with doctors is necessary. Hanger is continuing research toward the amputee's great hope, and will keep the medical profession informed of its progress.

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months after the date of completion of service.

(4) When a report is judged worthy by the Contest Committee, it will be accepted for the competition, and the envelope containing the name of the contestant will be opened. The contestant later will present his report in person before the Providence Medical Association at one of its regular meetings as arranged by the President. He will be notified, well in advance, of the date and hour of the meeting.

(5) Manuscripts received between January first and July first of any year will be considered for presentation at the October, November or December meetings. Those received after July first will be considered for presentation at the February, March, April or May meetings of the following

(6) Presentations should be straightforward reports of cases and should not include a review of the literature nor a general discussion of the subject illustrated.

(7) Contestants are not expected to submit illustrations with their manuscripts but are encouraged to use slides and tables if they so desire in their

presentations before the Association.

(8) Two or more men may collaborate in submitting a report, in which case the presentation will be made by one of them and any prize money will be equally divided.

(9) In making awards the Committee will consider the following three factors, giving approxi-

mately equal weight to each:

Medical interest and value of the material pre-

Excellence of the written manuscript as a case report.

Excellence in the manner of presentation before the meeting.

(Clearness and brevity are important. A time

limit of 15 minutes is imposed.)

(10) Prize-winning case reports will be submitted to the editor of the RHODE ISLAND MEDICAL JOURNAL and if published the author will be furnished with one hundred reprints at the expense of the Providence Medical Association

Prize Case Report Contest Committee of the Providence Medical Association CLARENCE E. BIRD, M.D., Chairman FRANK B. CUTTS, M.D. ALBERT H. JACKVONY, M.D. LOUIS I. KRAMER, M.D. ROBERT H. WHITMARSH, M.D.

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*Bureau of Health Education, A.M.A. Hygela, 24:332, May, 1946.

2nd ANNUAL ISAAC GERBER ORATION

The second annual Dr. Isaac Gerber Oration, sponsored by the Miriam Hospital staff was presented to a large audience at the Medical Library on March 30. Dr. Eske Windsberg, president of the staff, introduced Dr. Harry Gold, professor of clinical pharmacology of Cornell University Medical College who spoke on "Recent Developments in the Management of the Failing Heart".

An abstract of Dr. Gold's lecture is as follows:

A method for the routine treatment of congestive failure is described. It involves no new measures. The secret of its success lies in the way in which these measures are applied. It consists of five essential factors, 1 to 1.5 liters of milk daily as the sole diet, 1 glass of water every 3 hours, 1.2 mg. of digitoxin at one time followed by 0.2 mg. daily, a daily intramuscular injection of mercuhydrin, and a chart of the daily weight. The method is extremely simple and can be readily carried out at home or in the hospital. It requires a minimum of nursing care. The results with this method in 140 cases of congestive failure were compared with those in about 500 similar cases treated by various methods in common use, representing a cross-section of the practice in the hospitals of New York City. This comparison showed that the proposed method leads to complete relief of congestive failure in an average of about 6 days as compared with about 18 days with the other methods, that the incidence of complete relief is 90% as against 50%, that the death rate in the hospital is approximately 10% as against 24%.

The foregoing measures are continued with the object of dehydrating the patient to the point at which the optimum amount of extracellular fluid remains, which, for convenience, is labeled the "dry state", and which is assumed to be the case in the vast majority of individuals, when the weight ceases to fall. The technique is modified in accordance with indications in particular cases. A system of maintenance using body weight as a guide is described which prevents recurrences these constituting about 20% of all hospital admissions for

congestive failure.

CONFERENCE OF PRESIDENTS AND OTHER OFFICERS— ANNUAL MEETING, JUNE 5

Discussion of compulsory health plans, for medical care and for disability compensation, will highlight the Fifth Annual meeting of the Conference of Presidents and Other Officers of State Medical Associations to be held at Atlantic City on Sunday afternoon, June 5. The meeting will be held in the Rose Room of the Traymore Hotel, the day preceding the opening of the AMA general sessions, and it will be open to all physicians.

Cecil Palmer, English publisher, author, and journalist, will tell of the impact of socialized medicine on the British doctor and his patients. Palmer, now completing a tour of America, has been a brilliant spokesman for the British Society for Individual Freedom. An American viewpoint of the British health system will be given by W. Alan Richardson, editor of *Medical Economics*, now in England for a first hand study of all phases of the program.

With compulsory disability compensation programs operating in three states, and Washington and New York the latest to pass such laws, the Conference presents two speakers on this vital question: Edward H. O'Connor, managing director of the Insurance Economics Society of America, will discuss the legislation, and Dr. Bert S. Thomas, medical director of the California program, will tell of the medical implications of cash sickness compensation acts.

The AMA relationship to the state societies will be reviewed by Dr. George F. Lull, secretary of the AMA, and the problems facing the state association at the crossroads will be the subject of a talk by Dr. Clarence Northcutt, president of the Oklahoma State Medical Association. Plans are also pending for the presentation of views on national health legislation by a member of Congress.

Dr. Joseph H. Howard, past president of the Connecticut State Medical Society, is President of the Conference, and John E. Farrell, executive secretary of the Rhode Island Medical Society is the secretary-treasurer.

Next Meeting of the PROVIDENCE MEDICAL ASSOCIATION

Monday...October 3...at the Medical Library

N. E. DIABETES ASSOCIATION ANNUAL MEETING

Thayer Hall, City Hospital, Worcester, Mass., May 23, 1949, 4:00 p.m.

Clinical Program

- 1. NEUROPSYCHIATRIC ASPECTS OF DIABETES
 - Foster L. Vibber, Neuro-Psychiatrist Worcester City Hospital
- 2. POTENTIAL DIABETES Joseph A. Lundy, Assistant Physician Worcester City Hospital
- 3. NECROTIZING PAPILLITIS IN DIABETES
 - Edward F. Ramsdell, Assistant Physician Worcester City Hospital
- 4. PATHOLOGY OF NECROTIZING PAPILLITIS
 - Raymond H. Goodale, Pathologist Worcester City Hospital
- EXPERIENCE WITH DIABETIC COMA AT WORCESTER CITY HOSPITAL Albert E. Hall, Assistant Physician Worcester City Hospital
- 6. OPTIMISM AND DIABETES George Ballantyne, Physician Worcester City Hospital

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(Amendment effective January 1, 1949)

Question 5. Will surgical bills be paid in full under the plan?

This is an *important* feature of the plan. The benefits of the policy as regards *surgery*, *obstetrics*, *anesthesia*, and *surgical assistant's fee* will be accepted by participating physicians as full payment for their services to the subscriber whose total gross income from wages does not exceed the amount indicated:

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- (2) Individual with one dependent-\$3000
- (3) Individual with two or more dependents— \$3600

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BOOK REVIEW

CURRENT THERAPY, 1949, Howard F. Conn, Editor. W. B. Saunders Co., Philadelphia, 1949, \$10.00.

Current therapy is an excellent encyclopedic outline of medical and surgical treatment. It reaches the goal of the editor, which is to furnish the practitioner with authoritative information on the latest methods of accepted treatment. It achieves this end by having one or several recognized authorities endorse their usual routine of treatment in each disease. No attempt is made to diagnose. The entire book assumes a proper diagnosis and then sets forth accepted and endorsed schemes of management for that condition.

The entire field of medicine, with the exception of pediatrics as such, is covered in 647 pages. This has necessitated brevity, which when used in medical literature has often resulted in improving a work. The list of contributors is long and impressive . . . one section in medicine will serve to illustrate the pattern covered in the various sections of the book. In cardiovascular diseases William J. Kerr is the consultant and I. C. Brill, Harry Gold, William D. Stroud, George R. Herrman, Harold Feil, E. Sterling Nichol John J. Sampson, L. Whittington Gorham, David Scherf, Henry Brainerd, Philip A. Tumulty William P. Longmire Jr., Ephraim P. Engleman, Ann Peril Purdy, Paul D. White, Robert S. Palmer, Daniel W. Dadal, Lawrence N. Atlas, and R. Stanton Sherman have contributed plans of treatment in their sub-specialities. Reginald H .Smithwick contributes in this section his plan of surgery for hypertension. In all instances a recognized authority sets forth his signed scheme of treatment. Where differences of opinion exist between contributors and those differences have established alternate programs of therapy, both opinions are presented.

The book permits the physician to compare in any instance his own scheme of management with

RHODE ISLAND MEDICAL JOURNAL

accepted forma. Such an excellent check list should reduce the number of mistakes of omission.

It may be thought that the field covered is too broad. However, this disadvantage is offset by the fact that it is for the therapy of those conditions which the physician is qualified to treat but does not frequently encounter that he wished to consult authoritative schemes of therapy.

ROBERT V. LEWIS, M.D.

N. E. PEDIATRIC SOCIETY

The New England Pediatric Society is meeting in Providence on Wednesday, June 1st. Doctors who are interested are welcome to all the meetings. The dinner in the evening will be for the members and their guests. The first meeting will be a clinicopathological conference at the Rhode Island Hospital at noon. The afternoon session, also at the Peters House, will start at 2:30 P. M. and there will be a series of short papers and presentations of cases. There will be a dinner at the Agawam Hunt at 6:30 P. M. and at 7:30 P. M. Dr. Konrad E. Birkhaug will give a discussion of the present status of B.C.G. Any physician who is interested to hear Dr. Birkhaug will be welcome, but he should notify Dr. W. P. Buffum, Gaspee 1-3446, as the seating capacity is limited.

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JUNE ISSUE...R. I. MEDICAL JOURNAL



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